ERROR CORRECTION FORM

Sequence Number: | CIBMTR Recipient ID: | Initials:

Today's Date: Month Day Year 20__ | Infusion Date: Month Day Year 20__ | CIBMTR Center Number:

Form 2046 R4.0: Fungal Infection Pre-Infusion Data

Center: CRID:

Key Fields

Sequence Number: ______________________

Date Received: __ __ __ __ - __ __- __ __

CIBMTR Center Number: ______________________

CIBMTR Research ID: ______________________

Event date: __ __ __ __ - __ __- __ __

Infection Episode

Questions: 1 - 24

Information for this report should come from an actual examination by the Transplant Center physician, or the physician who is following the recipient pre-HCT / pre-infusion, or abstraction of the recipient's medical records.

1 Date of infection diagnosis: __ __ __ __ - __ __- __ __

Specify all diagnostic tests performed, which had a positive result, to determine the diagnosis of the fungal infection.

2 Radiographic findings (e.g. x-ray, CT, or MRI)

- Yes
- No
- Unknown

3 Specify imaging sites that supported the diagnosis of fungal infection (check all that apply)

- Abdomen / pelvis
- Bone
- Brain
- Chest
- Sinus
- Other imaging site

4 Specify other imaging site: ______________________

5 Pathology (e.g. biopsy, cytology)

- Yes
- No
- Unknown

6 Specify sample source that supported the diagnosis of fungal infection (check all that apply)

- Brain / central nervous system (CNS)
- Eye
- Liver
- Lung (includes sputum)
- Upper gastrointestinal (GI) tract (e.g. esophagus, stomach)
- Skin
- Spleen
- Other sample source

7 Specify other sample source: ______________________

8 Culture

- Yes
- No
- Unknown

9 Specify sample source that supported the diagnosis of fungal infection (check all that apply)

- Blood (includes whole blood, serum, or plasma)
- Bone
- Brain / central nervous system (CNS)
- Eye
- Liver
- Lung (includes sputum)
- Upper gastrointestinal (GI) tract (e.g. esophagus, stomach)
- Skin
- Spleen
- Other sample source

10 Specify other sample source: ______________________

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ERROR CORRECTION FORM

Sequence Number: CIBMTR Recipient ID: Initials:

Today's Date: Month Day 20 Year   Infusion Date: Month Day 20 Year   CIBMTR Center Number:

Form 2046 R4.0: Fungal Infection Pre-Infusion Data

Center: CRID:

11 KOH / Calcofluor / Giemsa stain

- Yes
- No
- Unknown

12 Specify sample source that supported the diagnosis of fungal infection (check all that apply)

- Bone
- Central nervous system (CNS)
- Liver
- Lung (includes sputum)
- Upper gastrointestinal (GI) tract (e.g. esophagus, stomach)
- Skin
- Spleen
- Other sample source

13 Specify other sample source: ______________________

14 Galactomannan assay

- Yes
- No
- Unknown

15 Specify sample source that supported the diagnosis of fungal infection (check all that apply)

- Blood (includes whole blood, serum, or plasma)
- Bronchial fluid (BAL)
- Cerebrospinal fluid (CSF)
- Other sample source

16 Specify other sample source: ______________________

17 1,3-Beta-D-glucan (Fungitell) assay

- Yes
- No
- Unknown

18 Specify sample source that supported the diagnosis of fungal infection (check all that apply)

- Blood (includes whole blood, serum, or plasma)
- Bronchial fluid (BAL)
- Cerebrospinal fluid (CSF)
- Other sample source

19 Specify other sample source: ______________________

20 PCR assay

- Yes
- No
- Unknown

21 Specify sample source that supported the diagnosis of fungal infection (check all that apply)

- Blood (includes whole blood, serum, or plasma)
- Bronchial fluid (BAL)
- Cerebrospinal fluid (CSF)
- Tissue
- Other sample source

22 Specify other sample source: ______________________

23 Specify tissue (check all that apply)

- Brain
- Eye
- Upper gastrointestinal (GI) tract (e.g. esophagus, stomach)
- Liver
- Lung
- Skin
- Other tissue

24 Specify other tissue: ______________________

Treatment of Infection

Questions: 25 - 30

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ERROR CORRECTION FORM

Sequence Number: CIBMTR Recipient ID: Initials:

Today's Date: Month Day 2 0 Year | Infusion Date: Month Day 2 0 Year | CIBMTR Center Number:

Form 2046 R4.0: Fungal Infection Pre-Infusion Data

Center: CRID:

Specify all medications received by the recipient from 7 days prior to the date of infection diagnosis until the end of the reporting period for this form. If the recipient received the medication, please record the date that the medication started.

25 Did the recipient receive any therapy between 7 days prior to the date of infection diagnosis and the date of contact for this reporting period?

- yes
- no

Antifungal Drugs (1) — **Questions: 26 - 29**

26 Antifungal drugs

- Amphotericin products (Amphocin, Fungizone, Ambisome, Abelcet, Amphotec)
- Anidulafungin (Eraxis)
- Caspofungin (Cancidas)
- Fluconazole (Diflucan)
- Isavuconazole (Cresemba)
- Itraconazole (Sporanox)
- Micafungin (Mycamine)
- Posaconazole (Noxafil)
- Voriconazole (Vfend)
- Other antifungal drug

27 Specify other antifungal drug: ______________________

28 Date therapy started

- Known
- Unknown

29 Date started: __ __ __ __ - __ __- __ __ ☐ Date estimated

30 What was the status of the infection? (at the last evaluation prior to the start of the preparative regimen)

- Ongoing
- Improved
- Resolved
- Unknown

First Name: ______________________

Last Name: ______________________

E-mail address: ______________________

Date: __ __ __ __ - __ __- __ __

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